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Influence of socio-economic factors on the mental health of vulnerable populations at risk in Kakuma refugee camp

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Abstract
The refugee experience is characterized by exposure in one's country of origin to numerous traumatic incidents during migration and daily stressors after settlement in the camps as a result of natural disasters, wars and persecution on the basis of their race, religion, political beliefs and social identity, who cannot rely on their country of origin to protect them. Although numerous studies on deaths, illnesses and physical traumas resulting from wars and disasters have been conducted, there are scanty longitudinal studies on how psychosocial issues influence mental health of vulnerable populations at risk and the problem-specific interventions used to address mental ill health. The prevalence of mental illnesses among refugees keeps increasing in spite existing psychiatric treatment options used to resolve the particular concerns associated with mental health. The objective of the study was to determine the influence of socio-economic factors on the mental health of vulnerable populations at risk in Kakuma refugee camp, Turkana County, Kenya.

Keywords: mental health, psychosocial issues, vulnerable populations at risk, socio-economic factors, problem-specific

1.0 Introduction

As reported elsewhere, tribulations attributed to post-migration resulting from violence and subsequent fleeing altogether, affects the psychological well-being of the populations, which fall victims of displacement (Hirani *et al*., 2022; Rajbangshi *et al*., 2021). Forcibly displaced populations typically report exposure to a high number of potentially traumatic events in their country of origin and during displacement (*et al*., 2018). Many refugees have already been traumatized in their country of origin, whether by war-related events, social violence, or abuse within their own families, and many have been further exposed to life-threatening situations during their flight, for example, surviving a perilous crossing of the Mediterranean, or encountering dangerous situations in the country of destination. In general, acts of violence such as rape, torture, and armed conflict have far more devastating effects on their victims than do natural disasters or accidents (Fegert *et al*., 2018).

Upon their arrival in the host countries, the refugees are constantly faced with several stressors stemming from the countries displaced from. Some of these factors are discrimination, insecurity about their legal status as well as acclimatizing on the new environment (Schick *et al*., 2016).

Persons with mental and psychosocial disabilities represent a significant proportion of the world's population (Park e*t al*., 2016). Although all refugees are vulnerable, the degree of vulnerability may vary based on certain risk factors such as age, gender, illnesses, disability and social status as (Mendola & Pera, 2022) ascertained. This then makes refugees particularly at risk for mental health problems. The prevalence and social distribution of mental health issues in countries with high incomes has been well established. Although the issue is increasingly being recognized in low- and middle-income countries, there is still a substantial gap in studies to quantify the problem, and in mental illness treatment measures, policies and services. The priority given to the prevention of mental illnesses and to the promotion of mental health by action on the social determinants of health needs to be increased considerably (WHO, 2014). It is understood that certain variables raise the risk of mental illnesses in refugees and migrants for example women are more likely than men to experience sexual exploitation and abuse during wars, displacement and even in the refugee camps. Higher rates of mental disorders are associated with exposure to traumatic occurrences before departure or during flight and problems with settlement and integration in the host countries. A research in three separate countries (Germany, Italy and the United Kingdom) of long-term refugees from the former Yugoslavia found that these factors raised the risk of mental illness in refugees in all three countries (WHO, 2018).

2. Theoretical framework

Trauma Theory

Contemporary trauma theory and social causation theory have been complementarily used to explicitly state how trauma and psychosocial issues influence the mental health of vulnerable populations at risk. Traumatic experience is defined as a situation that overwhelms the normal ability to cope (Ahearn e*t al*., 2017). Traumatic stressors cause neurological as well as biological reactions, causing the individual to shut down due to inability to integrate psycho-socio processes. The social causation theory explicates how socioeconomic determinants like poverty, prejudice, and social inequality play a role in the emergence of mental health issues (Gøtzsche-Astrup J., 2022).

3. Materials and methods

The study used descriptive research design. A descriptive design allows for the exploration of a wide range of variables that affect mental health of vulnerable populations at risk. Descriptive design furnishes the researcher with an opportunity to gain insight into the problem itself and also helps the research

team to see the need for the research (GradesFixer, 2019).

Data instrument tools used includes questionnaires, interview guides and FGD guides. Data was analyzed via descriptive and inferential statistics. Quantitative data was coded and analyzed descriptively and inferential statistics using Chi-Square goodness of fit in order to establish the level of significance of correlation between study variables. The quantitative data was analyzed using SPSS 26.0 and presented in tables, pie charts and bar charts. Qualitative data was analyzed using thematic technique analysis to support quantitative data and presented in form of verbatim reports.

3.1. Study area

The study was carried out in Kakuma Refugee Camp in Turkana County, Kenya. The camp is located in Turkana County which is in the Northwestern region of Kenya, which is generally hot and dry. The camp is situated 120 Kilometers from Lodwar District Headquarters and 95 kilometers from Lokichogio which is at the Kenya – Sudan border. Refugees come from various nationalities which include Sudan, Democratic Republic of Congo, Ethiopia, Uganda, Rwanda, Burundi, South Sudan and Somalia among others, who have lived in the area for over ten years. Nationals from South Sudan and Somalia respectively, comprise the highest number of refugees
in the camps (UNHCR, 2021). The camp is administratively divided into four sub-camps, Kakuma 1 to 4.

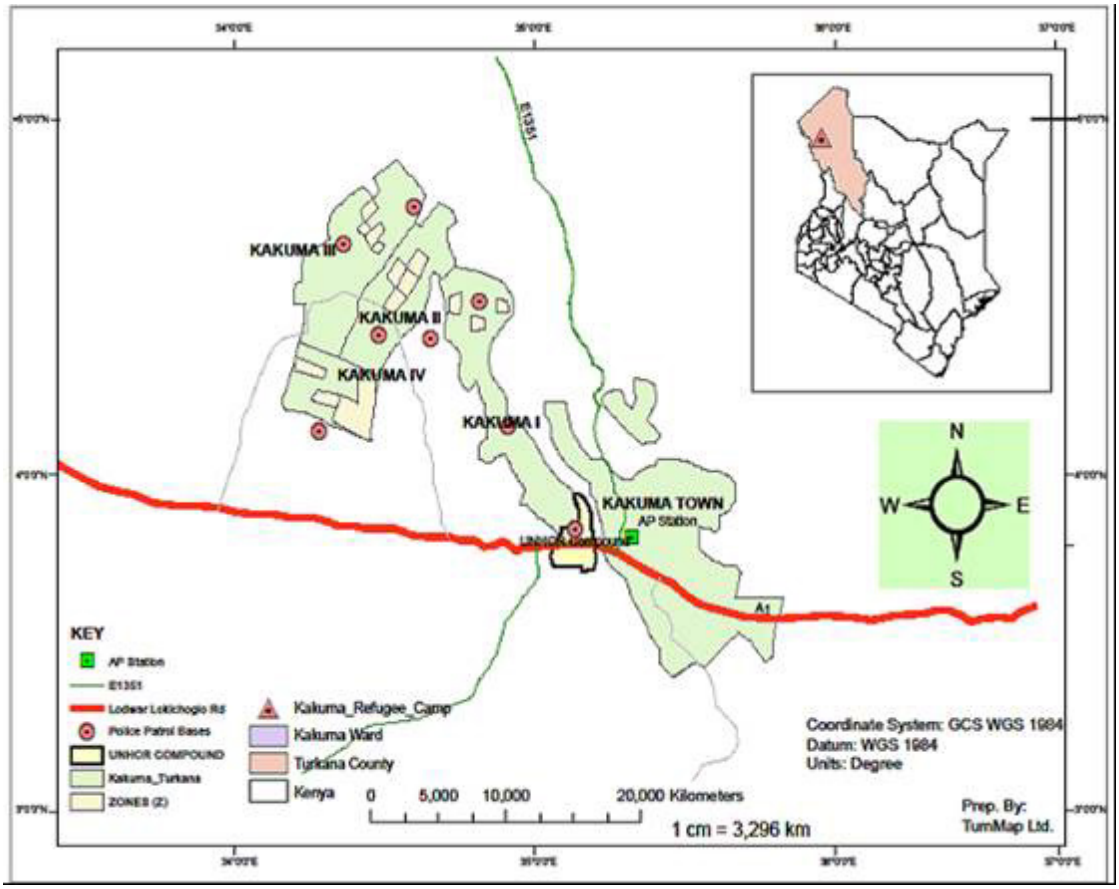

Figure 3. 1: Map showing Kakuma Refugee Sub-Camps
(Source: Researcher (2021)

3.2. Study population

The study population (38,530) included refugees and asylum seekers who are vulnerable and at greater risk of mental health illnesses sampled (394) as household heads. 12 (30% of 40) state and non-state actors were purposively sampled as key informants.

3.3. Sample size

The study followed the table sampling procedures proposed by Isaac and Michael (1981) and Smith (1983) on Appendix VII, who concluded that a sample size of 394 was adequate to reflect a population of 25000-499999. The number 394 stands for 38,530 families.

Table 3. 1: Sampling Head of Households

	A	B	C	D	E
Sampling Units (countries of origin)	Cluster Population (household heads)	Total Population of Clusters(Total population of clusters)	Number of sampled per cluster(No of HHDs)	No of sampled clusters (sample size)	% Per Cluster
South Sudan	17477	38530	179	394	45
Somali	7881		81		21
DRC	3650		37		9
Sudan	3562		36		9
Burundi	3270		33		8
Ethiopia	1904		19		5
Uganda	563		6		2
Rwanda	223		2		1
Total	**38530**		**394**		**100.0%**

Source: Researcher (2021).

3.4 Sampling procedure

Probability-proportional-to-size sampling was used whereby in the first stage, cumulative total of cluster population was calculated and number of clusters to be sampled was determined. In the second stage, the same number of individuals was sampled from each cluster irrespective of their cluster. Overall, the second stage compensates the first stage so that each individual in the population has the same probability of being sampled.

In this case, the primary sampling units and their population sizes are listed in column A. Each cluster has its own cluster population size (a). The cumulative sum of the population sizes (b=38530) is calculated in column B. The number of sampled clusters (d=394) was determined in column D. The number of individuals sampled from each cluster (c) was also determined in column C. The total population was divided by the number of clusters to be sampled to get the sampling interval (SI). A random number is chosen between 1 and the SI.

Probability Proportional to sample size (PPS) 1= (a x d) ÷ b

Prob 1= (a x d) ÷ b

a = cluster population

b= total population

d= number of clusters

Prob 1: Probability of each clusters being sampled = Cluster population ÷ total population

Prob 2: Probability of each individual to be selected from each of the sampled clusters = Number of individuals to be selected from each of the sampled clusters ÷ cluster population

Therefore, overall probability = Prob 1 × Prob 2

Overall weight = 1 ÷ Prob 1 × Prob 2

Table 3.2: Summary of Study Sampling Strategy

Study Population Units	Target Population	Sample Size	Sampling Methods	Methods of Data Collection
House Hold Heads Kakuma	38530	394	Stratified/ Proportionate &simple random	Questionnaire
State and Non-State Actors	40	12 (30%)	purposive	Interview & Observation
Community leaders	30	8 (30%)	Purposive	Interview& observation
Orphaned children	32	8 (25%)	Purposive	Interview& observation
Teenage mothers	30	8 (27%)	Purposive	Interview& observation
People with chronic illnesses/Disabilities	30	8 (27%)	Purposive	Interview& observation

Source: Researcher (2021)

4. Results and discussions

Social Support, Influence, Connections, and Integration

Table 4. 1: Social support and integration

	5(SA)	4(A)	3(U)	2(D)	1(SD)	Mean	STD
Food supply is adequate	15(4.4%)	35(10.2%)	37(10.8%)	94(27.3%)	163(47.4%)	1.9680	1.17636
The emergency shelters are appropriate	34(9.9%)	27(7.8%)	27(7.8%)	160(46.5%)	96(27.9%)	2.2529	1.22534
There are adequate educational opportunities	161(46.8%)	84(24.4%)	50(14.5%)	31(9.0%)	18(5.2%)	2.0145	1.20365
Essential healthcare services are available	115(33.4%)	127(36.9%)	55(16.0%)	29(8.4%)	18(5.2%)	2.1512	1.13279
Safety from violence is assured in the camp	19(5.5%)	43(12.5%)	99(28.8%)	70(20.3%)	113(32.8%)	2.750	1.21534

Public infrastructure system is reliable	7(2.0%)	30(8.7%)	71(20.6%)	71(20.6%)	165(48.0%)	1.9622	1.10460
Services are provided in a timely manner	17(4.9%)	31(9.0%)	53(15.4%)	42(12.2%)	201(58.4%)	1.8983	1.24005

Source: Researcher (2021)

According to the findings in table 4.1, majority of the respondents strongly disagreed with the statements provided in the table that is for example, 201(58.4%) out of 344 respondents strongly disagreed with timely provision of services in the camp, n=165(48.0%) indicated that public infrastructure is unreliable, n=113(32.8%) safety from violence is not guaranteed, n=163(47.4%) inadequate food supply. The results show that generally, food supply in the camps is inadequate, the emergency shelters are inappropriate, safety from violence is not assured, public infrastructure system is unreliable, and services are not provided in a timely manner. However, there are adequate educational opportunities (n=161) and availability of essential healthcare services (n=127).

Lack of access to adequate housing, shelter, education, and employment has far-reaching consequences. Poor socioeconomic situations after migration have been linked to an increased risk of acquiring depression symptoms in numerous studies (Bogic *et al.*, 2015).

Events of Social Disparity

	(D)	3(U)	4(A)
Uncertainty during asylum seeking process	139(40.4%)	105(30.5%)	100(29.1%)
Discrimination and social inclusion	77(22.4%)	133(38.7%)	134(39.0%)
Restrictions on capacity to work	70(20.3%)	55(16.0%)	219(63.7%)
Resettlement and acculturation challenges	61(17.7%)	69(20.1%)	214(62.2%)
Violence, threats or conflicts in the community	75(21.8%)	103(29.9%)	166(48.3%)
Grief from the loss of loved ones	62(18.0%)	55(16.0%)	227(66.0%)
Adjusting to and dealing with life in the camp	62(18.0%)	89(25.9%)	193(56.1%)
Disruption of family support, social network, and community structures	59(17.2%)	85(24.7%)	200(58.1%)

Table 4.2: Events of social disparity

From the results, majority of the respondents in the camps have experienced social disparity as vulnerable populations at risk as evidenced by numbers indicated by those who agreed to have experienced disruption of family support, social network and community structures (n=200), grief from loss of loved ones (n=227), restrictions on capacity to work (n=219) and resettlement and acculturation challenges (n=214). Stresses related to poor mental health commonly revolve around social alienation, discrimination, and racism (Wong *et al., 2017)*.

Economic Hardship

Table 4.3: Economic Hardship

	5(SA)	4(A)	3(U)	2(D)	1(SD)	Mean	STD
Obtaining employment	139(40.4%)	83(24.1%)	62(18.0%)	22(6.4%)	38(11.0%)	3.7645	1.33568
Financial constraint in funding daily expenditure	126(36.6%)	114(33.1%)	70(20.3%)	21(6.1%)	13(3.8%)	3.9273	1.07338
Limited opportunities to generate income	121(35.2%)	112(32.8%)	69(20.1%)	25(7.3%)	16(4.7%)	3.8663	1.11686
Access to land for farming	159(46.2%)	80(23.3%)	53(15.4%)	38(11%)	14(4.1%)	3.9651	1.19472
Housing affordability	99(28.8%)	72(20.9%)	49(14.2%)	43(12.5%)	81(23.5%)	3.1890	1.54874

Source: Field Data (2021)

With respect to data on economic hardship, majority of the respondents in the camps are experiencing economic hardship as shown by outstanding numbers of respondents who strongly agreed to challenges involving obtaining employment (n=139), financial constraints in funding daily expenditure (n=126), limited opportunities to generate income (n=121),access to land (n=159) and housing affordability (n=99).

Economic, environmental, psychological, emotional, and social difficulties (Haaken and O'Neill 2014) are added to the list of challenges that these immigrants encounter. Crumlish *et al*., (2010) found that unemployment can lead to mental health problems. Insufficient employment opportunities will hinder adaptation to the modern world (Ryan *et al*., 2008). Majority of Syrian refugees are forced to labor in the informal economy due to a lack of official employment possibilities (Wells *et al*., 2016). Asylum policies, work opportunities, shelter placements, and educational opportunities are all areas where program development and improvement can help ease the process of integration (Priebe *et al*., 2016).

Table 4.4: Model Summary for Socio economic factors and mental health

					Change Statistics					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.447[a]	.200	.198	.71303	.200	85.593	1	342	.000	1.536

a. Predictors: (Constant), Socio Economic

b. Dependent Variable: Mental Health

Findings in table 4.16 reveal a statistically significant association between socio economic factors and mental health among vulnerable populations at risk in Kakuma refugee camp. Specifically, the study data revealed an r square value of 0.20 signifying that 20.0% of the variance witnessed in mental health of the refugees was a result of socio-economic factors. The remaining 80% of the factors that influence mental health of refuges can be explained by other factors that were not part of this study which are explained by the error term.

Table 4.5: ANOVA model for Socio economic factors and mental health

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	43.517	1	43.517	85.593	.000b
	Residual	173.877	342	.508		
	Total	217.393	343			

a. Dependent Variable: Mental Health

Analysis of variance (ANOVA) output in table 4.17 for socio economic factors as a predictor of mental health among refugees had an F value of 85.593 that was statistically significant within 99% confidence interval with a P value=0.000. This implies that the regression model in Table 4.17 was well fitted to predict mental health issues among refugees in Kakuma Refugee camp.

Table 4. 6: Coefficients for Socio economic factors and mental health

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.166	.130		8.993	.000
	Socio Economic	.389	.042	.447	9.252	.000

a. Dependent Variable: Mental Health

The results in Table 4.18 revealed a beta coefficient of 0.447, which was significant at 99% confidence interval with a P value of 0.000. The dependent variable. It also means that Socio economic factors is a useful predictor of mental health. The regression equation to estimate the mental health as a result of changes in the socio-economic well-being therefore becomes; Y= 1.166 + 0.389 SE + Ɛ where Y= Mental Health, SE= socio economic factors and Ɛ is the error term. The implication for this finding is that, holding all other factors constant, a unit change in socio economic factors results in 0.389-unit changes in mental health of refugees in Kakuma refugee camp. Findings from this study were compared with findings from previous studies on the effect of socio-economic factors on mental health of refugees.

5. Conclusion

Overall conclusion of the study was that the mental health of vulnerable populations at risk is affected in varying magnitudes depending on age, social status, gender and health among other risk factors that this study has suggested for further research. The study findings offer psychosocial interventions based on a transdisciplinary approach for sustainable solutions towards addressing the mental health of vulnerable populations at risk among refugees in Kakuma camp. This study recommends prioritized socio-economic empowerment of the refugees, timely addressing of their psychosocial wellbeing, specialized psychosocial support interventions and a holistic approach in formulation of policies and procedures to safeguard the mental health of vulnerable populations at risk in Kakuma refugee camp.

Data availability

Data are available from the corresponding author upon request.

Ethical approval

The research permit was granted by the National Commission for Science, Technology, and Innovation (NACOSTI) License No. NACOSTI/P/20/7808. The protocol of the study was approved by Masinde Muliro University of Science and Technology Ethical Review Committee.

Conflict of Interest

The author declares that they have no competing interest.

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